Complete Summary

GUIDELINE TITLE

Surgical treatment of cancer of the colon or rectum.

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Surgical treatment of cancer of the colon or rectum. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 4 p. [5 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Cancer of the colon and/or rectum

GUIDELINE CATEGORY

Diagnosis
Evaluation
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Gastroenterology
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs.

TARGET POPULATION

Adult patients with colon and/or rectal cancer.

INTERVENTIONS AND PRACTICES CONSIDERED

Treatment

1. Preoperative chemoradiation therapy in selected patients
2. Open or laparoscopic surgical excision of tumor, bowel segment involved, and regional lymph nodes
3. Palliative surgical resection of primary tumor in presence of metastases
4. Concomitant bilateral oophorectomy in post-menopausal women
5. Transanal local excision of rectal cancer in small, early stage, low-lying tumors
6. Palliative treatment for unresectable rectal cancers (fulguration, laser photocoagulation, and endostenting)
7. Adjuvant radiation therapy and chemotherapy for advanced rectal cancers

MAJOR OUTCOMES CONSIDERED

- Length of hospital stay
- Survivial rates after surgical resection
- Local cancer recurrence or metastatic cancer

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Operative Treatment

Surgical removal is the preferred treatment for colorectal cancer. Surgical treatment is indicated in nearly all patients with newly diagnosed cancer of the large intestine unless survival is unlikely or life expectancy is very short due to advanced cancer or other diseases. Even in the presence of metastases, palliative surgical resection of the primary tumor is advisable to prevent further bleeding and eventual obstruction of the lumen.

Operative treatment consists of wide surgical resection of the involved bowel segment and regional lymphatic drainage. Primary anastomosis of a prepared bowel is possible in elective cases. In post-menopausal women, bilateral oophorectomy is recommended because of the combined risks of micro-metastases and primary ovarian cancer.

Although resection for cancer of the colon or rectum can be carried out laparoscopically, these techniques are still experimental. Preservation of the sphincters and avoidance of colostomy is preferred in rectal cancer if eradication of the cancer is also achieved. Transanal local excision of rectal cancer may be appropriate and curative for selected patients with small, early stage, and low-lying tumors. Palliative treatment for unresectable rectal cancers includes fulguration, laser photocoagulation, radiation therapy, and endostenting.

Radiation therapy and chemotherapy are used for advanced disease and in conjunction with surgical resection. While radiation therapy has little or no role in management of colon cancer, it is an important treatment modality for rectal cancer. Bulky rectal cancers may be treated preoperatively to improve resectability. For stage II (invasion into the muscularis propria of the rectal wall) or stage III rectal cancer (metastases to regional lymph nodes), radiation therapy is a useful preoperative or postoperative adjunct and is also used in combination with chemotherapy.

Patients with colon cancer extending through the bowel wall, with or without lymph node metastases (T3N0, T3N1), and those with tumors that do not extend through the bowel wall with positive nodes (T2N1) should be considered for preoperative or postoperative adjuvant chemotherapy.

Qualifications for Performing Operations on the Colon

Surgeons who are certified or eligible for certification by the American Board of Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent should perform both emergency and elective operations on the colon. These surgeons have successfully completed at least five years of surgical training after medical school graduation and are qualified to perform colon operations. The qualifications of the surgeon should be based on training (education), experience, and outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Increased survival rates after surgical resection: Five-year survival rates vary from 90% for tumors confined to the mucosa and submucosa to less than 5% for those with distant metastases. Overall, about 70% of these patients can be cured by operation.
- Earlier diagnosis of locally recurrent or metastatic cancer with scheduled follow-up.

POTENTIAL HARMS

Postoperative complications of resection for colorectal cancer generally involve infections related to the bacterial flora of the large bowel. The most common postoperative complication is wound infection (2 to 4% in elective cases), which is minimized by mechanical and antibiotic bowel preparation and prophylactic intravenous antibiotics. Other risks include bleeding, anastomotic leakage, pelvic abscess, damage to neighboring organs (such as spleen or ureter), sexual and urinary dysfunction, and wound dehiscence.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines have been written by the Patient Care Committee of the Society of Surgery of the Alimentary Tract (SSAT). Their goal is to guide PRIMARY CARE physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the range of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately but the reader must realize that clinical judgement may justify a course of action outside of the recommendations contained herein.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Surgical treatment of cancer of the colon or rectum. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 4 p. [5 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2000)

GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

GUIDELINE COMMITTEE

Patient Care Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Committee Members: Thomas R Gadacz, MD (Chairman); L William Traverso, MD; Gerald M Fried, MD; Bruce Stabile, MD; Barry A Levine, MD.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates the previously issued version, J Gastrointest Surg. 1999 Mar-Apr;3(2):210-1.

An update is scheduled every two years.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Society for Surgery of the Alimentary Tract, Inc. Web site.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 28, 2000. The information was verified by the guideline developer as of May 30, 2000.

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